

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155178</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/31/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER-FOUNTAINVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>609 W TANGLEWOOD LN</b> <b>MISHAWAKA, IN 46545</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00169955, Complaint IN00170289, Complaint IN00170290, and Complaint IN00170566.</p> <p>Complaint IN00169955 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00170289 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00170290 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00170566 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 29 - 31, 2015</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 12 Medicaid: 75 Other: 10 Total: 97</p> <p>Sample: 8</p> <p>Golden Living Center - Fountainview was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Investigation of Complaint IN00169955, Complaint IN00170289, Complaint IN00170290, and Complaint IN00170566.  Quality Review 04/01/15 by Lisa McColly	F 000			